South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of
Long Term Health Care Administrators
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11329 • Columbia • SC 29211-1329 Phone:
803-896-4544 • Contact.llr@llr.sc.gov • Fax: 803-896-4515
www.llronline.com/POL/LongTermHealthCare/

EMPLOYMENT REFERENCE FOR LICENSE APPLICATION

(MUST BE COMPLETED BY EMPLOYER FOR EACH PLACE OF EMPLOYMENT)

Applicant's Name:_____

The above referenced person has applied for licensure by the South Carolina Board of Long Term Healthcare Administrators. In order for the applicant to become licensed an employment reference form must be completed by all facilities they have worked at. Time is of essence and timely completion of this form is requested. Once completed, please return to the Board office at the above listed address.

Place of Employment _____

Address: _____

Reference Name (Authorized person filling out this form): _____

Day-time Phone Number: _____ Email: _____

Type of Facility_____ Facility Licensed By _____

License Number_____ Applicant's Job Title _____

Dates of Employment _____ Employment Status: ☐ Full-Time ☐ Part-Time

Number of Employees Supervised _____ Number of Beds _____

Applicant's Supervisor _____ Administrator/Owner_____

Check the departments or areas the applicant was/is responsible for:

- BUSINESS AND FISCAL MANAGEMENT
  ☐ Business Office ☐ Finances
- DIRECT PATIENT CARE
  ☐ Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy
  ☐ Activities ☐ Social Work (Admissions and Marketing) ☐ Chaplaincy
- SUPPORTING SERVICES
  ☐ Dietary ☐ Maintenance ☐ Engineering ☐ Pharmacy
  ☐ Laundry ☐ Environmental Services

QUESTIONNAIRE

1. Was/Is the applicant's job performance satisfactory? ☐ YES ☐ NO

   Comments: _____

   _____

   _____

2. Would you be willing to rehire him/her if a vacancy existed? ☐ YES ☐ NO

   Comments: _____

3. Based on your knowledge of this person and/or personnel records, would you recommend him/her for employment as a long term health care administrator? ☐ YES ☐ NO

   Comments: _____

   _____

   _____

4. Were or are you the applicant's immediate supervisor? ☐ YES ☐ NO

   If no, what is the basis of your familiarity with applicant's job performance? _____

   _____

5. Describe the work skills and attributes that the applicant has demonstrated that would enhance their work as a long term health care administrator: _____

   _____

   _____

DOCUMENTATION OF WORK HOURS

Mark one of the following:

☐ Applicant worked part time during their period of employment. *(Complete Section A and skip Section B)*

☐ Applicant worked a combination of part time and full time during their period of employment. *(Skip Section A and complete Section B)*

Section A. PART-TIME EMPLOYMENT

1. Shift(s) applicant worked: _____

2. Total number of part-time hours worked during peak hours (7 a.m. to 7 p.m.), answer 2(a) or 2(b).

   a. Employment of 12 months or less: _____

   b. Employment of more than one year, list total hours per year:

      Year _____ Hours _____

      Year _____ Hours _____

      Year _____ Hours _____

      Year _____ Hours _____

3. Number of staff applicant supervised during shift(s): _____

Section B. COMBINATION OF PART-TIME EMPLOYMENT AND FULL-TIME EMPLOYMENT

1. Period(s) of part-time employment: _____ to _____
_____ to _____
_____ to _____

2. Shift(s) applicant worked during part-time employment:_____

3. Total number of part-time hours worked during peak hours (7 a.m. to 7 p.m.), answer 3(a) or 3(b).

   a. Employment of 12 months or less: _____

   b. Employment of more than one year, list total hours per year:

      Year _____ Hours _____

      Year _____ Hours _____

      Year _____ Hours _____

4. Number of staff applicant supervised during part-time employment: _____

5. Period(s) of full-time employment: _____ to _____
_____ to _____
_____ to _____

6. Shift(s) applicant worked during full-time employment:_____

7. Total number of full-time hours worked during peak hours (7 a.m. to 7 p.m.), answer 7(a) or 7(b).

   a. Employment of 12 months or less: _____

   b. Employment of more than one year, list total hours per year:

      Year _____ Hours _____

      Year _____ Hours _____

      Year _____ Hours _____

8. Number of staff applicant supervised during full-time employment: _____

Required: Attach a detailed description of departments or areas of responsibility and or company job description.

I hereby affirm that the information provided on this form and any attachments are true and accurate and I am the authorized person to provide this information by this employer.

Signature: _____ Date: _____

Print Name: _____ Title: _____

Business Email: _____ Business Phone: _____